Technical Assistance Report, Inmate Medical, Mental Health & Suicide Prevention & Management Services and Practices

Snohomish County Correctional Facility

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53. Critical Component #9: Critical Incident Debriefing

A shift from rehabilitation to a more custodial approach, an increase in long-term sentences, overcrowding, and more violent and mentally ill offenders led Cheek and Miller (1979) to examine the effects of stress in staff and inmates in the New Jersey Department of Corrections.

Cheek & Miller (1982) also investigated the strategies that the Department implemented to reduce those stressors. Brodsky (1982) conducted one of the earlier analyses of correctional stress from an organizational and

cultural perspective. The evidence indicated that correctional employees experience a significant amount of stress in their work, which may lead to high job turnover, high rates of sick leave and troubled relationships with inmates, other staff, and family members. Lindquist and Whitehead (1986) investigated burnout, job stress and job satisfaction among southern correctional officers. They found that 20% to 39% experienced burnout and stress but that only 16% expressed job dissatisfaction. It was suggested that correctional officers mask their dissatisfaction to prevent facing job changes. There was no analysis or implication regarding the effect this could have on families.

Stohr (1994) and associates studied stress in contemporary jails by examining jails in five areas across the U.S. They found that stress in workers was a serious problem and approaching dangerous levels in some facilities. The contributing factors were primarily related to management and organizational methods. There was less stress when fair compensation,investment in employee development and participatory management practices were employed.

Similarly, Wright, Saylor, Gilman and Camp (1997), in a study of U.S. Federal Bureau ofPrisons' employees, found lower job-related stress a factor when workers were involved in decision making.

Although not new to correctional employees on the front line, workplace violence was identified as having a negative impact on employees' wellness in the 1990s. The National CrimeVictimization Survey (NCVS) report for 1992-1996 (U.S. Dept. of Justice, 1998) revealed that the field of Law Enforcement was the second largest group in the nation to experience workplace violence. Prison guards experienced non-fatal workplace violence at the rate of 117.3 per 1,000 workers. Additional investigations of staff victimization have been cited in the literature (Andring, 1993; Dowd, 1996; Seymour & English, 1996; VandenBlos & Bulatao, 1996).

From November 21 through December 4, 1987, prisoners rioted and took hostages in Federal Prisons in Oakdale, Louisiana and Atlanta, Georgia (National Victim Center [NVC], 1997).

Bales (1988) reported about the stressors and follow-up for the hostages including a family resource center. There was no indication of pre-incident stress inoculation or family support planning. Additional hostage situations that reached national media attention were Attica, New York, 1971, Wyoming State Penitentiary, 1988, and Pennsylvania State Correctional Institution, Camp Hill, 1989 (NVC, 1997).

Throughout the 1980s and 1990s, the recognition of the need for crisis intervention after a critical incident became apparent. The earliest crisis intervention programs for correctional employees were conducted post-incident. Bergman and Queen (1987) credited the retention of employees after the riot at Kirkland Correctional Institution Columbia, South Carolina to the "critical incident debriefing" (Mitchell, 1983; Mitchell & Everly, 1993) conducted immediately after the incident. Van Fleet (1991) also referred to debriefing traumatized correctional staff to mitigate stress that could lead to posttraumatic stress disorder (PTSD). Training workshops and training guides/manuals became available (Concerns of Police Survivors [COPS], 1996; Finn & Tomz, 1997; NVC, 1997; U.S. Office of Personnel Management, 1998). Directly or indirectly, the resources referred to Critical Incident Stress Management (CISM) (Everly & Mitchell, 1997).

Traditionally, in the correctional field any type of assistance offered to employees' and their families was post-incident, usually at the employees or families' request and in the form of referrals to the agency's Employees Assistance Program or private contractors. Little mention is made of preventive or stress inoculation programs for employees and families at the front end or when entering correctional employment. On the other hand, police (COPS, 1996; NationalInstitute of Justice [NIJ], 1997) and firefighting agencies have initiated family awareness and educational programs, which range from a few hours to several weeks.

An Introduction to Critical Incident Stress Management

A critical incident is defined as "any event which has a stressful impact sufficient enough to overwhelm the usually effective coping skills of either

an individual or a group are typically sudden, powerful events outside of the range of ordinary human experiences" (Mitchell & Everly, 1993). Most employees entering the criminal justice system recognize that verbal and minimal physical abuse from those in their care, custody, and control is a reality of the job. Critical incidents and stressors experienced by employees in correctional, prison, and forensic settings include: held hostage, riot, physical/sexual assault, death or serious injury in line of duty, suicide of inmate or employee, use of lethal force on inmate, participation in execution and witness to any of the above.

Historically, the approaches to help staff deal with critical incidents and stressorsfall into three broad categories including:

(1) Employee Assistance Program (EAP), a contracted service with the state, agency or facility. Traditionally, the EAP provider is typically an individual mental health clinician (i.e., counselor, social worker, and psychologist). Since employees in these settings tend to be cautious and somewhat suspicious of mental health providers and outsiders, a few EAP programs include clinician-trained peer support personnel selected from the employees likely to be represented in an event.

(2) Peer Support Program (PSP) which consists of non-clinician employees, who are representative of the workforce, and trained in crisis intervention.

(3) Critical Incident Stress Management (CISM) Program, the International Critical Incident Stress Foundation (ICISF) model. The CISM Team is "described as a partnership between professional support personnel (mental health professionals and clergy) and peer support personnel (employees) who have received training to intervene in stress reactions" (Mitchell & Everly, 1993). Professional support personnel are required to have academic training at the master's degree or higher level and/or recognition of their training and skills through certification or licensure. They must also have education, training and experience in critical incident stress intervention.

Components of a Comprehensive CISM Program

A comprehensive CISM program is multi-faceted (Mitchell & Everly, 1993; PDOC, 1992). Pre-incident prevention and stress inoculation are essential. All employeesreceive education and training in everyday and work-related stress awareness and stress management techniques as well as how to access the EAP program and CISM team when necessary, while attending Basic Training Academy. Employees whose job requires direct contact with inmates/patients attend biannual refresher stress management classes. Managers receive training in recognition of employee stress and referral procedures. Families and significant others are provided similar stress awareness and coping skills and how to access referral services at the Family Academy.

CISM team development, member selection and training needs to be well-planned and foster a partnership between employees, management and labor relations. A CISM Program policy/standards and procedures manual, applicable to the agency, must be established. Best results are achieved if team membership is voluntary. A selection committee comprised of management and employees/ labor representatives should develop an application form and include an interview in the selection process.

Team members, professional and peer, must be trusted and accepted by their fellow employees. Peer members must be representative of the employee population including custody, maintenance, counseling, education, medical, clerical, etc. It is recommended that each facility have a team available for rapid deployment. In order to respond to major events, in large systems, regional teams composed of members from various facilities are also suggested.

Although there are similarities in the training programs available, this article and model adheres closely to the ICISF standards. All team members should be required to complete ICISF Basic Critical Incident Stress Debriefing Training. Peer Support/Crisis Intervention Strategies is also recommended. All members should also have an understanding of Incident

Command system, if used in their setting, and specialized units such as Emergency Response, Hostage Recovery and Hostage Negotiation Teams. The CISM team and specialty teams should participate in joint training exercises at least once annually.

The CISM Program services should include:

1. On-scene support (usually provided by peer support members during a major/prolonged event).

2. Demobilization or de-escalation (brief intervention to assist employees in making the transition from the traumatic event back to routine or stand-by duty, formal debriefing to follow in several days).

3. Defusing (a three-phase group crisis intervention provided immediately or within twelve hours after the event to mitigate the effects of the stressors and promote recovery, usually twenty to forty-five minutes in duration).

4. Debriefing (a seven-phase group crisis intervention process to help employees work through their thoughts, reactions, and symptoms followed by training in coping techniques, usually lasting one and one-half to two hours).

5. One-on-one support (individual intervention if a single or small event and a group intervention is not possible or additional individual assistance is deemed necessary after a group process).

6. Significant other/family defusing/debriefing (services may be provided separately from traumatized employees).

7. Line-of-duty death support (defusing provided immediately after event for staff, team assists family, and a debriefing provided for staff after the funeral).

8. Referrals (team member recommends and instructs employee to access additional support/treatment through EAP or other resources).

9. Follow-up (team leader or designated member contacts employee(s) and/or employee(s) supervisor a few days after team services).

Records and Program Evaluation

Client(s) confidentiality must be maintained. However, in order to maintain service continuity and program quality improvement minimal record keeping is necessary. A request for service form including time of event, nature of incident, number ofpersonnel involved, contact person and contact number will assist the team leader in selecting team members and establishing meeting location and time. The service provided form should include information from the request form and a summary or themes of reactions, thoughts, and symptoms presented, educational material provided, and coping techniques recommended and if referrals were made.

Individual(s) names and comments are not recorded.

The team leader may, with the majority consensus and participants' permission, provide administrative staff with a report of recommendations to improve conditions or remedy situations that led to the critical event. In most situations consumer satisfaction will be determined informally through follow-up with the participants and from supervisory staff. However, after major events, a participant's satisfaction questionnaire is recommended. A combination of checklist, multiple choice and general comment format works best in this employment setting.

Interagency and Community Support

Traditionally correctional facilities are scattered through the state and many times located in rural areas. Correctional CISM Teams can be a resource for smaller counties and municipalities and provide services for jails, probation and parole agencies, police and community emergency

responders. The Correctional CISM Team professionals may act as consultants or supplement communities volunteer peer teams. The CISM teams can, along with other correctional special response teams, assist communities affected by a disaster. The Correctional CISM Teams may also work very effectively with other State agencies such as state police and probation and parole.

FINDING(S): There does not appear to be a formal policy or practice for CISM, in part due to very few jail deaths within the past five years. Additionally, there does not appear to be a coordinated policy with local community mental health services to provide CISM services.

RECOMMENDATION(S):

? Develop and implement comprehensive CISM policies and procedures.

? This procedure is not the same as mortality review debriefing. Instead, this refers to a formalized opportunity for involved or affected staff members to talk about their thoughts and feelings about a possibly difficult critical incident, such as a death or suicide attempt, so as to try to deal more effectively with their difficult or troubling feelings. Policy shouldindicate that this opportunity is available and should indicate who has the responsibility for planning and implementing it. Policies and procedures should be developed to coordinate both internal and external CISM services.

? Traditionally, a critical incident debriefing focuses on the experiences and needs of staff involved in the stressful event. Inmates can also experience post-event trauma. It is important to recognize that inmates who are exposed to suicides or other serious trauma while incarcerated may suffer temporary and/or long term psycho-emotional harm. It is therefore important that a comprehensive critical incident debriefing policy and action plan includes providing similar services to appropriate inmates. Again, policies and procedures should be developed to coordinate both internal and external CISM services and include services for inmates.